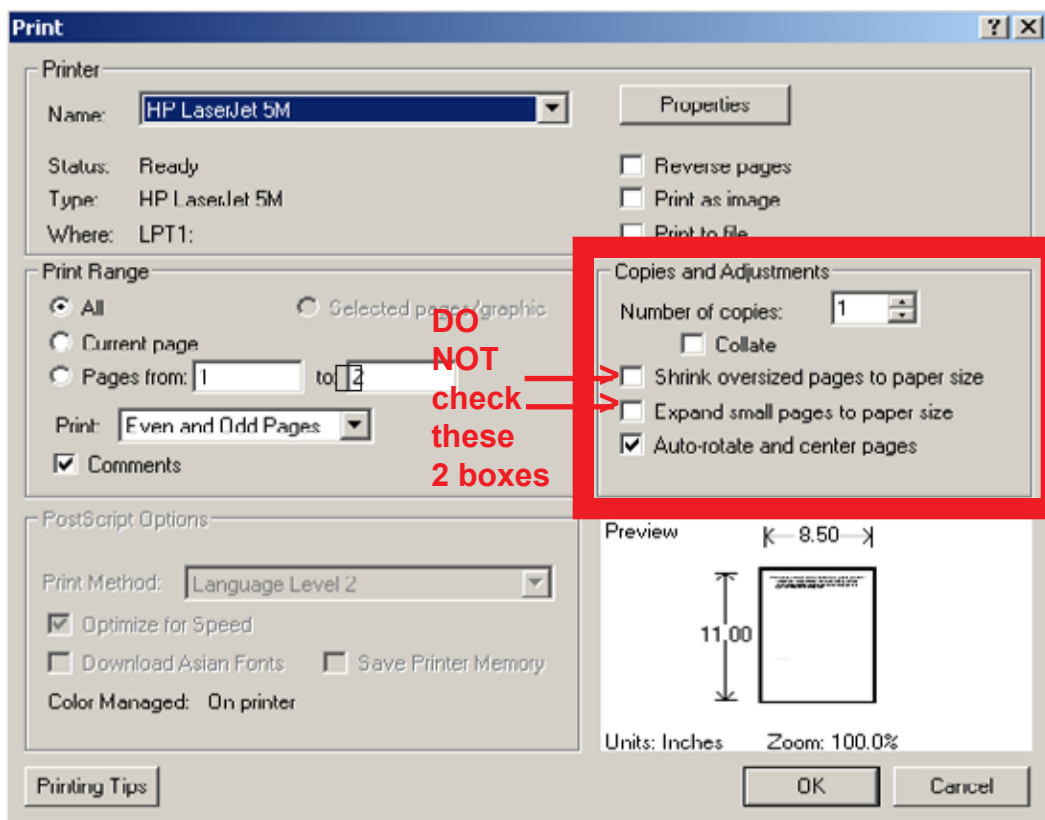


Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Dispensing Optician Licensure by Endorsement Application Packet

1. 647-070 ... Contents List/SSN Information/Deposit Slip 1 page
2. 647-058 ... Dispensing Optician Licensure by Endorsement Information 1 page
3. 647-066 ... Application for Endorsement as a Dispensing Optician 4 pages
4. 647-022 ... Verification of Licensure and Examination—Dispensing Optician 1 page
5. 647-061 ... Washington State Dispensing Optician Program State Law Examination 2 pages

B. Important Social Security Number Information:

- * Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
- * Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099.**



Cut along this line and return the form below with your completed application and fees.



Dispensing Optician—Endorsement

DEPOSIT SLIP

NAME (PLEASE PRINT)

Revenue Section

P.O. Box 1099

Olympia, Washington 98507-1099

DATE

Please note amount enclosed, and return
with your application.

\$

☐ Check

☐ Money Order

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Washington State Department of
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Dispensing Optician Licensure By Endorsement Information

A license to practice as a dispensing optician may be issued without examination to an individual who is currently licensed in another state that has licensing standards substantially equivalent to those currently applicable in Washington State.

NOTE: Licensure based solely on the American Board of Opticianry (ABO) examination or the National Contact Lens Examiner's (NCLE) examination is not interpreted as being substantially equivalent to current Washington State requirements.

Application Requirements

1. A completed application and application fee of \$100.00
 - a. Fees may be paid with either a personal check or money order made payable to *The Department of Health*.
2. Documentation from the state in which the applicant is currently licensed sufficient to establish that the states licensing standards are substantially equivalent to the licensing standards currently applicable in Washington State to include:
 - a. A current copy of the law for each state(s) in which an applicant holds a license.
 - b. Detailed information on the content of the required licensing examinations.
3. A completed open-book state law questionnaire.
4. Documentation of completion of four clock hours of AIDS education as required in chapter 246-12 WAC part 8.
5. Verification from all states in which the applicant has ever held a license, whether active or inactive, indicating whether the applicant is or has been subject to charges or disciplinary action for unprofessional conduct or impairment.
6. Official high school transcripts or equivalency forwarded directly from the issuing agency

Completed application and appropriate fees may be mailed to:

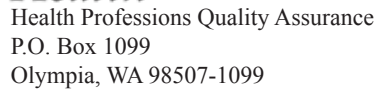
The Department of Health
Dispensing Optician Program
Post Office Box 1099
Olympia, WA 98507-1099

Supporting documents, or correspondence should be sent to:

Department of Health
Dispensing Optician Program
PO BOX 47870
Olympia, WA 98504-7870

If you have any questions, please contact Health Professions Section 4 at 360-236-4825.

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LICENSE

I. Demographic Information

APPLICANT'S NAME		LAST		FIRST		MIDDLE INITIAL	
MAILING ADDRESS							
CITY				STATE		ZIP	
COUNTY							
NOTE: Your certification document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.							
TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)			RESIDENCE TELEPHONE		SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW.)		
					<div> <div></div> <div></div> </div>		
SENDER			BIRTHDATE (MO/DAY/YR)		PLACE OF BIRTH (CITY/STATE)		MAIDEN NAME
<input type="checkbox"/> Female <input type="checkbox"/> Male			<div> <div></div> <div></div> <div></div> </div>				
Have you ever been known under any other name? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, other name(s):							
PLEASE INDICATE WHICH OPTION APPLIES TO YOU:							
<input type="checkbox"/> Completed High School <input type="checkbox"/> General Education Development (G.E.D.)							

List all states where licenses are or were held.

[illegible]

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐
- “Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
- 1a. If you answered “yes” to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).
- 1b. If you answered “yes” to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.
- (If you answered “yes” to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in “1b” so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)
2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain..... ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Chemical substances”** includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.
3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?..... ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances?..... ☐ ☐
- “Currently”** means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, and includes at least the past two years.
- “Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.
- Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.**
5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:
- a. the use or distribution of controlled substances or legend drugs?..... ☐ ☐
- b. a charge of a sex offense?..... ☐ ☐
- c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)..... ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:
- a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐
- b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐
- c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, explain and provide copies of all judgments, decisions, and agreements. ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?..... ☐ ☐

4. Education

[illegible]

5. Professional Experience

In chronological order, list all professional experience. (Exclude activities listed under other sections.)
(Attach additional 8 1/2 x 11 sheet if necessary.)

[illegible]

6. AIDS Education and Training Attestation

I certify I have completed the minimum of 4 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

DATE

7. Applicant's Attestation

I, _____, certify that I am the person described and identified
NAME OF APPLICANT

in this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and they independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

Official Use Only
Washington State Records Center



Health Professions Quality Assurance
Dispensing Optician Program
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4825

Verification of Licensure and Examination Dispensing Optician

TO APPLICANT: Complete top portion in full and forward to state in which you hold or have held a license/certificate as a Dispensing Optician (there may be a fee for this service).

Name (Last, First, Middle Initial) _____

Street Address _____

City _____ State _____ ZIP _____

License No. _____

I authorize the release of the information asked for below to the Washington State Dispensing Optician Program.

Signature _____

All fees are the responsibility of the licensee named above.

TO STATE BOARD: The above individual is applying for licensure as a Dispensing Optician in Washington State. To assist the Board in its review, please provide us with a copy of the law under which the applicant was initially licensed as well as an outline of the state examination upon which the applicant was awarded, indicating the subject matter covered in the exam and if known, how the exam was weighted. Complete the following information and return to the above address. Thank you for your cooperation.

Name of Licensee _____

License No. _____ Date of Issue _____ Expiration Date _____

License was issued on the basis of:

☐ Examination in your state: ☐ Written Examination ☐ Practical Examination

☐ NCLE Examination ☐ ABO Examination

☐ Reciprocity/Endorsement from (indicate state) _____

☐ Registration (no examination required)

☐ Other (explain) _____

Legal/disciplinary action? ☐ Yes ☐ No

If yes, please explain _____

SIGNATURE OF VERIFIER

SEAL

TITLE

STATE BOARD

DATE

This Form May Be Duplicated

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Health Professions Quality Assurance
PO Box 1099
Olympia, WA 98507-1099
(206) 236-4825

Washington State Dispensing Optician Program State Law Examination

Please circle the correct response.

1. An unlicensed person may perform mechanical work upon inert matter in an optical office, laboratory or shop.
 - a. True
 - b. False
2. To sell completely preassembled articles such as spectacles, eyeglasses, magnifying glasses and goggles, a person must be licensed under the dispensing optician practice act (RCW 18.34).
 - a. True
 - b. False
3. A licensed dispensing optician may diagnose human ailments, deficiencies, deformities and/or injuries.
 - a. True
 - b. False
4. A dispensing optician may fit contact lenses only upon a written prescription of physician or optometrist.
 - a. True
 - b. False
5. A license to practice as a dispensing optician MUST be conspicuously displayed in the place of business of the licensee.
 - a. True
 - b. False
6. A dispensing optician may supervise a maximum of _____ apprentices at any one time.
 - a. 1
 - b. 2
 - c. 3
 - d. 5
7. A dispensing optician renews their license:
 - a. Annually
 - b. Every 2 years
 - c. Every 3 years
 - d. Every 10 years
8. How many hours of continuing education must be acquired?
 - a. 15 hours each year
 - b. 30 hours every 3 years
 - c. Varies with state of residence
 - d. Continuing education is not required
9. _____ of these credits MUST relate to contact lenses?
 - a. 5
 - b. 15
 - c. No set amount
 - d. 30
10. Who maintains a record of the licensee's continuing education hours?
 - a. Dispensing Optician Examining Committee
 - b. The Department of Health
 - c. The licensee
 - d. Opticians Association of Washington

11. Which of the following is NOT required as minimum equipment for a Washington licensed dispensing optician while fitting contact lenses?
 - a. Slit Lamp or biomicroscope
 - b. Lensometer
 - c. Keratometer
 - d. Binocular indirect ophthalmoscope
12. Washington licensed dispensing opticians shall maintain patient records a minimum of:
 - a. Seven years
 - b. Ten years
 - c. Five years
 - d. Eight years
13. Which of the following is considered unprofessional conduct?
 - a. Providing false information when applying for a license
 - b. Misrepresentation or fraud in any aspect of the conduct of the business or profession
 - c. False or misleading advertising
 - d. All of the above
14. A notation of "OK for contacts" on the prescription for corrective lenses indicates to the practitioner fitting the contact lenses that:
 - a. The patient has been provided with trial lenses
 - b. The patient has expressed an interest in wearing contact lenses
 - c. The initial fitting and follow-up must be completed within six months of the date of the eye examination
 - d. The patient's vision plan covers contact lenses
15. A prescription may be written for less than two years if:
 - a. Warranted by the ocular health of the eye
 - b. The prescription is for extended wear contact lenses
 - c. The patient is new
 - d. The prescription is more than plus or minus three diopters
16. If a prescription is written for less than two years, the prescriber must:
 - a. Contact the optical lab
 - b. Send a notice to the patient prior to its expiration
 - c. Maintain a separate log of prescriptions that expire in less than two years
 - d. Enter an explanatory notation in the patient's record and provide a verbal explanation to the patient at the time of the eye examination
17. No practitioner may dispense contact lenses based on a prescription that is over:
 - a. One year old
 - b. Five years old
 - c. Two years old
 - d. Three years old
18. The finalized contact lens prescriptions shall be available to the patient or the patient's designated practitioner for replacement lenses and may be transmitted by:
 - a. Telephone
 - b. Facsimile or mail
 - c. Provided directly to the patient in writing
 - d. All of the above